

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH57 022910  
State File No. 6212

FILED JUL 11 1957

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>   |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE _____ Mo. b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>   |  | c. LENGTH OF STAY (In this place) <b>3 yrs. 6 mo.</b>   |  | c. CITY OR TOWN <b>St. Louis</b>   |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital</b>  |  |   |  | e. STREET ADDRESS (If rural, give location) <b>4225a W. Evans</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b>   |  | b. (Middle) _____   |  | c. (Last) <b>Smith</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>June 30 1957</b>  |  |
| 5. SEX <b>female</b>  |  | 6. COLOR OR RACE <b>colored</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>  |  | 8. DATE OF BIRTH <b>July 30, 1884</b>  |  |
| 9. AGE (In years last birthday) <b>62</b>   |  | 10. IF UNDER 1 YEAR Months <b>10</b> Days <b>0</b>  |  | 11. IF UNDER 24 HRS. Hours <b>1</b> Min. _____   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>   |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Mo.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |
| 13a. FATHER'S NAME <b>Monroe ?</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Alice Dill</b>   |  | 14. NAME OF HUSBAND OR WIFE <b>Wm. Thomas</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>Unknown</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME <b>Alice Anderson</b> ADDRESS <b>4550a Garfield</b>  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.                                     |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) <b>Generalized Arteriosclerosis</b><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 yrs.</b><br><b>4 1/2 yrs.</b>   |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION <b>420.0</b>   |  |  |  | 20. AUTOPSY? <b>2</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                           |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |  | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____   |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR? _____  |  |  |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>12-21-53</b> , 19____, to <b>June 30</b> , 1957, that I last saw the deceased alive on <b>June 30</b> , 1957, and that death occurred at <b>2:20 P.m.</b> , from the causes and on the date stated above. |  |   |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>   |  |   |  | 23b. ADDRESS <b>5800 Arsenal St.</b>   |  | 23c. DATE SIGNED <b>7/1/57</b>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>  |  | 24b. DATE <b>7/6/57</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>   |  | 24d. LOCATION (City, town; or county) (State) <b>St. Louis, Missouri</b>   |  |
| DATE REC'D BY LOCAL REG. <b>JUL 3 57</b>  |  | REGISTRAR'S SIGNATURE <b>Carl Smith</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>G.B. Roone</b>   |  | ADDRESS <b>1221 N. Grand</b>   |  |

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision.

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 396

P. O. Address 1221 W. 1st St.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.